Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STEPHEN E EARLE MD
PO BOX 33577
SAN ANTONIO TX 78265

Respondent Name
LIBERTY INSURANCE CORP

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-07-2279-01

MFDR Date Received
DECEMBER 5, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Documented in op rep.CPT codebook pg. 185. Preauth obtained."

Amount in Dispute: $5,534.28

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill has been adjusted to correctly pay at the providers contracted rate."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 9, 2005	CPT Code 22899-99 Unlisted procedure, spine	$369.62	$0.00
	CPT Code 63030 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	$1,171.00	$925.11
	CPT Code 63035 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (List separately in addition to code for primar	$281.00	$256.48
	CPT Code 20975 Electrical stimulation to aid bone healing; invasive (operative)	$241.28	$220.83
	CPT Code 63685-99 Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	$611.00	$279.61
December 9, 2005	CPT Code 69990-52 Microsurgical techniques, requiring use of operating	$309.00	$0.00

	microscope (List separately in addition to code for primary procedure)		
	CPT Code 20938 Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)	$263.00	$0.00
	CPT Code 62290 Injection procedure for discography, each level; lumbar	$233.00	$0.00
	CPT Code 22558-52 Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar	$1,925.00	$918.86
TOTAL		$5,534.28	$2,600.89

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202, effective August 1, 2003, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. Former 28 Texas Administrative Code §134.600, effective March 14, 2004, 29 TexReg 2349, requires preauthorization for specific healthcare treatment and services.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits

   - 150- Payment adjusted because the payer deems the information submitted does not support this level of service.
   - X322-Documentation to substantiate this charge was not submitted or insufficient to accurately review this charge.
   - 97- Payment is included in the allowance for another service/procedure.
   - X212-This procedure is included in another procedure performed on this date.
   - 45- Charges exceed your contracted/ legislated fee arrangement.
   - P303-This service was reviewed in accordance with your contract.
   - U899-Procedure has exceeded the maximum allowed units of service.
   - 62- Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
   - X170-Pre-authorization was required , but not requested for this service per TWCC Rule 134.600.
   - U693-By clinical practice standards, this procedure is incidental to the related primary procedure billed.
   - X901-Documentation does not support level of service billed.
   - X815-This procedure is incidental to the primary procedure, and does not warrant separate reimbursement.

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Is CPT code 22899-99 unbundled from another procedure billed on this date? Is the requestor entitled to reimbursement for CPT code 22899-99?
3. Is the requestor entitled to reimbursement for CPT code 63030?
4. Is the requestor entitled to reimbursement for CPT code 63035?

5. Does a preauthorization issue exist over codes 20975 and 63685-59?
6. Is the requestor entitled to reimbursement for CPT code 20975?
7. Is the requestor entitled to reimbursement for CPT code 63685.59?
8. Is CPT code 69990-52 unbundled from another procedure billed on this date? Is the requestor entitled to reimbursement for CPT code 69990-52?
9. Does the documentation support billing of CPT code 20938?
10. Is CPT code 62290 unbundled? Is the requestor entitled to reimbursement for CPT code 62290?
11. Does the documentation support billing of CPT code 22558-52? Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason codes "45 and P303". Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on June 1, 2012 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. According to the explanation of benefits, the respondent denied reimbursement for CPT code 22899-99 based upon reason code "97 and 212." Per NCCI edits this code is not global to any other code billed on this date.

   The respondent also denied reimbursement for CPT code 22899-99 based upon reason codes "150 and X322." CPT code 22899 is defined as "Unlisted procedure, spine." A review of the operative report finds that the requestor billed this code for "Examination under anesthesia with pain study."

   28 Texas Administrative Code §134.202(c)(6) states "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments."

   CPT code 22899 does not have a relative value unit assigned; therefore, reimbursement shall be provided in accordance with 28 Texas Administrative Code §134.1.

   CPT code 22899 relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1 that requires "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

   - The requestor does not discuss or explain how reimbursement of $500.00 for code 22899-99 is a fair and reasonable reimbursement.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

3. A review of the submitted medical bill finds that the requestor billed codes 63030-50 and 63030 on the disputed date of service. The respondent paid for CPT code 63030-50. CPT code 63030 is unilateral by definition; therefore, if performed on both sides of the spine (bilaterally), the requestor must append modifier "50." The requestor appended modifier "50" to 63030 to indicate the service was performed bilaterally.

   Per Rule 134.202(b), the maximum allowable reimbursement, (MAR) is determined by locality. A review of Box 32 on CMS-1500 indicates that the zip code 78233 is the locality. This zip code is located in Bexar County.

   28 Texas Administrative Code §134.202(c)(1) states "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%."

   The Medicare allowable for CPT code 63030 in Bexar County is $858.08. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $1,072.60. The requestor billed for this procedure bilaterally (63030 and 63030-50); therefore, this amount multiplied by 150% = $1,608.90. The difference between the MAR and amount paid is $683.79. As a result, the amount ordered is $925.11.

4. According to the explanation of benefits, CPT code 63035 was denied reimbursement based upon reason code "U899".

   On the disputed date of service, the requestor billed CPT code 63035 and 63035-50. The respondent paid for CPT code 63035-50. CPT code 63035 is unilateral by definition; therefore, if performed on both sides of the spine (bilaterally), the requestor must append modifier "50." The requestor appended modifier "50" to 63035 to indicate the service was performed bilaterally.

   The Medicare allowable for CPT code 63035 in Bexar County is $205.19. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $256.48. CPT code 63035 is an add-on code; therefore, it is exempt from multiple procedure discounting. The difference between the MAR and amount paid is $256.48. As a result, the amount ordered is $256.48.

5. CPT codes 20975 and 63685 were denied reimbursement based upon lack of preauthorization.

   Former 28 Texas Administrative Code §134.600(h) requires preauthorization for non-emergency "(1) inpatient hospital admissions including the principal scheduled procedure(s) and the length of stay; and (3) spinal surgery, as provided by Texas Labor Code §408.026."

   On November 8, 2005, the requestor obtained preauthorization approval from Intracorp for "Inpatient Lumbar Surgery with Laminectomy & Discectomy with Length of Stay for 3 days." Therefore, a preauthorization issue does not exist, and reimbursement is recommended for CPT codes 20975 and 63685.

6. The Medicare allowable for CPT code 20975 in Bexar County is $176.67. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $220.83. CPT code 20975 is exempt from multiple procedure discounting. The difference between the MAR and amount paid is $220.83. As a result, the amount ordered is $220.83.

7. The Medicare allowable for CPT code 63685 in Bexar County is $447.38. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $559.22. CPT code 63685 is subject to multiple procedure discounting; therefore, $559.22 X 50% = $279.61. As a result, the amount ordered is $279.61.

8. CPT code 69990 was denied based upon reason code "U693." Per CCI edits, CPT code 69990 is a component of CPT code 62290. A modifier is not allowed to differentiate the service. The Division finds that the allowance for CPT code 69990 is included in the allowance of another procedure performed on the disputed date. As a result, reimbursement cannot be recommended.

9. The respondent denied reimbursement for CPT code 20938 based upon reason codes "150 and X901". A review of the operative report indicates "Harvesting and preparation of bone graft." The code descriptor for 20938 is "Autograft for spine surgery only (includes harvesting the graft); structural, bicortical or tricortical (through separate skin or fascial incision) (List separately in addition to code for primary procedure)." The requestor did not support billing of code 20938. As a result, reimbursement is not recommended.

10. CPT code 62290 is defined as "Injection procedure for discography, each level; lumbar."

    Per CCI edits, CPT code 62290 is a component of CPT codes 63030. A modifier is not allowed to differentiate

the service.

The Division finds that the allowance for CPT code 62290 is included in the allowance of another procedure performed on the disputed date. As a result, reimbursement cannot be recommended.

11. The respondent denied reimbursement for CPT code 22558-52 based upon reason codes "150 and X901". A review of the operative report indicates "The patient underwent anterior interbody arthrodesis at L4-5." The code descriptor for 22558 is "Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar." The requestor's documentation supports billing of code 22558. As a result, reimbursement is recommended.

    The requestor appended modifier 52 to code 22558. Modifier 52 is defined as "Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service."

    The Medicare allowable for CPT code 22558 in Bexar County is $1,470.19. Per 28 Texas Administrative Code §134.202(c)(1) this amount is multiplied by 125% equals a MAR of $1,837.73. CPT code 22558 is subject to multiple procedure discounting; therefore, $1,837.73 X 50% = $918.86. As a result, the amount ordered is $918.86.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,600.89.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,600.89 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/30/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.